WHAT IS HEALTHCARE GROUP?

With one million uninsured Arizonans and only 28 percent of Arizona small businesses offering employer-sponsored health coverage, Healthcare Group of Arizona (HCG) is an important State-sponsored program.

Initially funded by a grant from the Robert Woods Johnson Foundation, Healthcare Group of Arizona was created by the Arizona State Legislature in 1985 to provide affordable and accessible healthcare coverage to small businesses with two 50 or less employees and political subdivisions.

Healthcare Group is a State-sponsored program that provides healthcare coverage to uninsured businesses in Arizona. Differing from health plans that perform underwriting on each individual, Healthcare Group is required to consider age, gender, health status-related factors, group size, geographic area, and community rating when establishing premiums for the program. Healthcare Group is a guaranteed-issue plan, which means that there is no medical underwriting and no one can be turned down for a medical condition.

Unlike commercial health plans in the state of Arizona, which are regulated by the Arizona Department of Insurance, Healthcare Group of Arizona is a State-sponsored program that is administered under Title 36 of the Arizona Revised Statutes and provides quarterly reports to the Joint Legislative Budget Committee.

Your company currently qualifies for Healthcare Group coverage if you have between 2 and 50 enrolling employees, have been in business in Arizona for 60 days prior to your application and have been without group healthcare coverage for at least three (3) months. As a pre-paid premium-based plan, employers may choose to contribute to the premiums or can offer the plan directly to their employees at no cost to the business.

Healthcare Group offers a managed-care option through two Health Plan Networks: Mercy Healthcare Group and University Healthcare Group. And since all employees are not the same, Healthcare Group offers benefit plan options to fit a variety of health needs, lifestyles and budgets.

Dental benefits are offered through *Employers Dental Services* or *Principal Plan Dental PPO* and vision benefits are offered through *Avesis, Inc*.

PARTICIPATION

How does a small business qualify for HCG?
In order to be eligible for HCG, a small business must meet the following criteria:

- Be actively conducting business within Arizona for at least 60 days.
- Provide proof of revenue.
- Meet "bare period" requirements.
- Have a minimum of two (2) and a maximum of fifty (50) eligible employees on the effective date of its original enrollment, or be a political subdivision.

All employees who work an average of 20 hours per week and are paid at least State minimum wage are considered full-time, eligible employees.

Do all of my employees need to enroll in a health plan through Healthcare Group?
HCG does have participation requirements that need to be met by all groups. The participation requirements include:

- Employers must enroll a minimum of two (2) and a maximum of fifty (50) eligible employees on the effective date of its original enrollment.
- Employers with 2-5 eligible employees are required to enroll 100% of these employees in an HCG medical plan or provide a valid waiver from individuals who have other qualifying healthcare coverage.
- Employers with 6-50 eligible employees are required to enroll 80% of these employees. Valid waivers are accepted from individuals with other qualifying coverage.

What is a valid waiver?
A valid waiver is provided by an employee who meets the requirements of A.R.S. 36-2912(D)(1)-(3). Employees with proof of other existing healthcare coverage who elect not to participate in the Healthcare Group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

- Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.
- Medical assistance is provided by a government-subsidized healthcare program.
- Medical assistance is provided pursuant to section 36-2982, subsection I.

Can I receive coverage if I am self-employed?
Only businesses with a minimum of two (2) eligible employees are eligible to enroll in the Healthcare Group program.

Do I need to submit proof of previous insurance with my enrollment form?
Yes. In order to prevent any possible denial of claims it is best to submit this form at the time of enrollment. The health plans use this proof as a means to reduce or eliminate pre-existing condition waiting periods. You can obtain this letter of creditable coverage from the following sources:

- Group health plan (insured or self-insured)
- An individual insurance policy
- Medicare
- Medicaid (AHCCCS)
- TRICARE
- A health benefits risk pool
- The Peace Corps
- Indian Health Services (IHS)
- The Federal Employee Health Benefits Plan (FEHBP)

Why do I need to be in business in Arizona for 60 days before I can apply for HCG?
Arizona Administrative Code R9-27-301 states that only employers who have been in business at least 60 days in Arizona before applying qualify for Healthcare Group participation.

Why must an employee work 20 hours a week to be eligible for HCG?
Arizona Revised (A.R.S.) Statute 36-2912 states that for an employee to be considered full-time and eligible for coverage, the employee must work at least 20 hours per week.

Who determines the percentage of required participation?
Participation rates are regulated through the Arizona Revised Statute 36-2912, which states participation requirements for HCG eligibility.

PRE-EXISTING CONDITIONS

What is a pre-existing condition?
A pre-existing condition is defined in A.R.S. 36-2912(AA)(10) as: "'Pre-existing condition' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information."

Are there any pre-existing condition limitations to HCG coverage?
Coverage for services related to a pre-existing condition or complications relating to the pre-existing condition will not begin until 12 consecutive months or, in the case of a late enrollee, 18 months, have elapsed from the member's enrollment date. The length of time may be shortened or eliminated by the amount of credit given for periods of prior Creditable Healthcare Coverage. For prior coverage to reduce this pre-existing condition waiting period, a member's effective date of coverage with HCG must occur without a break in coverage of more than 63 days (excluding the employer's eligibility waiting period or any other mandatory waiting period) of any prior creditable coverage ending. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited toward the pre-existing waiting period.

BARE PERIOD

Notification of Bare Period
Effective September 27, 2008, HB2275 A.R.S. 36-2912 (C) prohibits Healthcare Group of Arizona (HCG) from enrolling an employer group sooner than ninety days (90) days after the date that the employer's health insurance coverage under an accountable health plan is discontinued.

The period without insurance coverage, called the "bare period," applies only to the business itself and not to individual employees. If a commercial carrier currently insures your group, the business will not be eligible for HCG coverage until the business has been without medical coverage for three months. If your business is currently uninsured but was covered by a commercial carrier prior to your application to HCG, your business must remain uninsured for the remainder of the "bare period" in effect at the time of your enrollment before you and your eligible employees can be enrolled in HCG. The bare period does not apply to political subdivisions.

I am a sole proprietor or only have one eligible employee. Am I or my one employee eligible to enroll in HCG?
Effective September 27, 2008, HB2275 A.R.S. 36-2912 (B) prohibits Healthcare Group from enrolling groups with only one eligible employee.

My business is currently uninsured and meets the bare period requirement, but many of my employees have their own insurance coverage or are covered under their spouse's policy. Does the bare period apply to us?
The bare period only applies to the business. If your business meets the "bare period," then you and your eligible employees will be able to enroll in HCG immediately – even if some of your employees have coverage from other sources.

I have been with HCG for many years, but last month our group was terminated for non-payment of premiums. We applied for re-enrollment a few days later. Since we were insured when we reapplied, are we required to wait three (3) months before our coverage begins again?
Yes. An Employer Group that is terminated for non-payment of premium is not eligible to re-enroll for coverage until 90 days after the termination. This means that the Employer Group will be required to reapply as if a new Employer Group and will be subject to pre-existing condition exclusion limitations. All benefit limitations, deductibles, and/or pre-existing condition exclusion waiting periods will be reset.

My business was insured until 2 months ago when our commercial insurance company discontinued the health plan we selected. Are we subject to the bare period?
No. If your business had commercial coverage and the accountable health plan discontinues offering the health plan of which the employer is a member, the bare period does not have to be met by the employer.

PROOF OF BUSINESS

What documents do you need from me to show proof of business?
Businesses with two or more paid employees must submit at least one of the following documents:
- Most recent Individual Federal Income Tax Return with all Schedules and Attachments,
- Most recent Corporate Federal Income Tax Return with all Schedules and Attachments,
- Current Arizona Sales Tax Returns showing active sales.

And, in addition, one of the following documents:
- Current Unemployment Tax and Wages Report with Employee List, or
- Current Workers Compensation Report with Employee List.

PROVIDER INFORMATION

How can I find out if my physician is part of one of the health plan networks?
HCG has two managed care networks from which to choose in Arizona at this time. The *Healthstyles* managed care plans are made up of: Mercy Healthcare Group and University Physicians Healthcare Group.

Mercy Healthcare Group
602.798.2800 / 800.780.2300
www.mercyhealthcaregroup.com

University Healthcare Group
520.874.5290 / 800.582.8686
www.universityhealthcaregroup.com

RATES

How often can I expect a rate increase?
Premium increases are based on actuarial reviews by an independent actuary based on projected and actual cost of providing healthcare benefits to eligible HCG members. Generally, premium increases occur one time a year, usually in the month of January. However, if an employee changes an age band, this will also increase the premium at annual renewal.

If the business is located in one county and the employee lives in another, which county does HCG use to rate the employee?
Rates are based on the county in which the business is physically located for employees of that business.

EMPLOYER CONTRIBUTION

Is there a mandatory contribution for the employer?
No, there is not a mandatory employer premium contribution. Studies show that if there is a contribution by the employer, more employees will join the health plan. Unlike traditional insurance companies, HCG does not require employer contributions, but they are encouraged.

ADDITIONAL QUESTIONS ABOUT HEALTHCARE GROUP

Is this an individual plan?
No. Healthcare Group is a group plan for small businesses.

Is this an Arizona Health Care Cost Containment System (AHCCCS) plan?
No. Healthcare Group is a State-sponsored program designed to offer the uninsured small businesses in Arizona healthcare coverage. It is administered by the Director of AHCCCS, but is not a Medicaid program.

What coverage is available for me if I travel out of the state or out of the country?
Emergency services are covered anywhere in the United States but the member is responsible to pay the out-of-network coinsurance. If admitted to an out-of-network hospital, the member will be transported to an in-network participating health plan network hospital when determined to be medically stable by the Medical Director.

The member or provider must notify the health plan network within 48 hours after Emergency Medical Services are initially provided if possible. There is no coverage outside of the United States.

GROUP RENEWAL

Do I need to complete paperwork to continue my coverage each year?
As with any other health plan, HCG has an annual renewal period. It is at the annual open enrollment that businesses can renew and make changes to their coverage. HCG has simplified the renewal paperwork process, moving the renewal to an electronic format online. Renewal notifications are sent four months prior to the renewal effective date, and the business is provided an open enrollment period of 30 to 45 days to make changes. If the renewal is not completed by the employer within the open enrollment period, the business will be automatically renewed into the same or closest available plan option(s). If the same plan options are available, the subscribers and members will remain on the same plan. If there has been a change in the coverage offered for the re-enrollment, HCG will re-enroll the employer in the plan that is closest to the previous healthcare coverage.

DEDUCTIBLES

What is a deductible?
Deductible means the annual fixed-dollar amount of covered expenses that the Member must pay before the HCG Plan starts to pay for covered services. The Member is also subject to the co-payment and coinsurance in addition to the deductible. ***This amount is accumulated on a calendar year from January 1st to December 31st and may not coincide with the renewal date of the employer.***

Members pay for their covered services and the services of their dependents until the entire deductible amount has been paid by the Member. Once the entire deductible amount has been paid, the member then is only responsible to pay co-payments and coinsurance for covered services and HCG pays for the remainder of the covered services.

The maximum total deductible for an insured family is two (2) times the dollar amount for an individual. Each family member does not have to meet the individual deductible separately; one or more family members can satisfy the family deductible.

HOW TO ENROLL

If your business is interested in enrolling in HCG, go to **www.hcgaz.com** and click on "Looking for a Health Plan". For additional questions, please contact us via e-mail at newbusiness@hcgaz.com or at 602.417.6755 or 800.247.2289 (outside Maricopa County).